PRINTED: 07/18/2011 FORM APPROVED

ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391								
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY					
AND PLAN OF CORRECTION	identification number: 155258	a. building 00 b. wing	COMPLETED 06/23/2011					
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						

NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE			
COLINIT	DVOIDE MANOR LIEALTIL & LIVING COMMUNITY	205 MARINE DRIVE			
COUNTR	RYSIDE MANOR HEALTH & LIVING COMMUNITY		ANDER	RSON, IN46016	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0000					
	This visit was for a Recertification and	EU	0000	Ms. Kim Rhoades	•
		1.0	000	Indiana Sttatte Departtmentt ofi Healtth	
	State Licensure Survey.			Long Term Care Division	
	G			2 N. Meridian Stt.	
	Survey dates: June 20, 21, 22, and 23,			Indianapolis, IN 46204-3006	
	2011				
	F 77 1 000160				
	Facility number: 000160			hulo 9 2011	
	Provider number: 155258			July 8, 2011	
	AIM number: 100267190			Dear Ms. Rhoades:	
	Survey team:			Please find enclosed tthe Plan ofi	
	Donna M. Smith, RN, TC			Correctton tto tthe annual	
	Toni Maley, BSW			Recerttficatton and Sttatte Licensure	
	Tammy Alley, RN			Survey conductted on June23, 2011.	
				This letter is tto infiorm you tthatt tthe	
	Census bed type:			plan ofi correctton attached is tto serve as Counttryside Manor Healtth	
	SNF/NF: 92			& Living Communitty's credible	
	Total: 92			allegatton ofi compliance We allege	
				compliance on July 23, 2011. We are	
	Census payor type:			requesttng a desk review fior tthis	
	Medicare: 39			plan ofi correctton	
	Medicaid: 43			Ifi you have any fiurtther questtons	
	Other: 10			please do nott hesittatte tto conttactt me	
	Total: 92			att(765)649-4558.	
	10001. 72			Sincerely,	
	Sample: 19			"	
	Supplemental sample: 3			Sttephanie Ingram H.F.A.	
	Supplemental sample. 3			Administtrattor	
	These deficiencies also reflect state				
	findings cited in accordance with 410 IAC				
	16.2.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NUJQ11

Facility ID:

000160

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BLUE DING (COMPLETED)		
	155258	A. BUILDING B. WING		06/23/2011
		205 M	ARINE DRIVE	
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	•			
resident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial statuc conditions or clinical tertreatment significant in her psychosocial statuc conditions or clinical tertreatment significant in adverse consequence form of treatment facility as specified. The facility must a resident and, if known there is a change in reside State law or regular paragraph (b)(1) of the facility must resupdate the addression and the same resident and the same resident and the same resident and the same resident and the same regular paragraph (b)(1) of the facility must resupdate the addression and resident and the same resident and	with the resident's physician; by the resident's legal an interested family member accident involving the sults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a salth, mental, or as in either life threatening all complications); a need to inficantly (i.e., a need to sting form of treatment due uences, or to commence a ment); or a decision to ge the resident from the drin §483.12(a). Iso promptly notify the pown, the resident's legal interested family member ange in room or roommate excified in §483.15(e)(2); or ant rights under Federal or ations as specified in of this section.			
-	review and interview, the	F0157	F157	07/23/2011
	A facility must immresident; consult wand if known, notifirepresentative or awhen there is an aresident which respotential for requiring significant change mental, or psychosideterioration in helpsychosocial statuconditions or clinical alter treatment significant change mental, or psychosocial statuconditions or clinical terreatment significant change mental, or psychosocial statuconditions or clinical terreatment significant change mental, or psychosocial statuconditions or clinical terreatment significant change in resident and, if known adverse consequence form of treatment facility as specified. The facility must are sident and, if known are sident and, if known are sident and the facility must are sident as specified. The facility must are sident as specified state law or regular paragraph (b)(1) or the facility must resident's legal registerity segal registerity member.	PROVIDER OR SUPPLIER EYSIDE MANOR HEALTH & LIVING COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Quality review completed 6/28/11 Cathy Emswiller RN A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested	A facility must immediately inform the resident; consult with the resident's legal representative or an interested family member when there is an accident involving in conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	ROVIDER OR SUPPLIER RYSIDE MANOR HEALTH & LIVING COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL REGULATORY OR LAC IDENTIFYING INFORMATION) Quality review completed 6/28/11 Cathy Emswiller RN A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED
		155258	B. WIN			06/23/2	011
					ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF I	PROVIDER OR SUPPLIE	R		205 MA	RINE DRIVE		
	RYSIDE MANOR H	EALTH & LIVING COMMUNITY		ANDER	RSON, IN46016		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	1 *	ensure the physician was			I. The M.D. for patient #6 has		
		dicated for high blood			notified. 1:1 inservicing has to provided for the nurse/nurses		
	_	1 of 7 residents reviewed			did not notify the MD of the b		
	for physician no	tification of blood sugars			sugar outside of the ordered		
	in a sample of 1	9. (Resident # 6)			parameters.		
	Findings Include:				II. Current diabetic patients w accuchecks and blood sugar parameters will be reviewed f		
	The record for Resident # 6 was reviewed				last 30 days to determine if an		
	on 6/20/11 at 2:30 p.m. The resident's				patients had blood sugars outs	-	
	current diagnoses included, but were not				the parameters. This review v		
	limited to, Diabetes.				include determining appropria		
					M.D. notification. Any identi		
	Current physicia	nn orders indicated an			patients will have M.D. notific	cation.	
	1	he physician if blood			III. A systemic change include	ed that	
	I	n 60 or greater than 350 as			all patients with a blood sugar		
	1 -	re. The original date of			outside of the ordered parame	ters	
	order was 5/15/1	•			will be recorded on a physicia		
	order was 3/13/1	11.			telephone order form. Physic	ian	
	The Mess 2011 N	Nadication Administration			orders will be reviewed daily	1 TT. 5	
	1 -	Medication Administration			(Monday through Friday) by t Manager or designee to detern		
	l ` ´	indicated on 5/24/11 at 8			that appropriate M.D. notifica		
	1 ~	nts's blood sugar was 352.			has occurred.	-	
		p.m., the resident's blood			Training will be provided to li	censed	
	1 -	At 8 p.m., the resident's			nurses on appropriate notifica		
		ained high at 379. The			physician for blood sugars ou		
		nysician notification of			the ordered parameters. The t	_	
	any the high blo	od sugars.			will also include recording pa		
					change of condition on a phys order form.	ician	
	On 6/21/11 at 4:	45 p.m., additional					
	information was	requested from the			IV. The Director of Nursing a	and /or	
	Director of Nurs	sing regarding the lack of			designee will review all accur		
		cation of the high blood			results daily (Monday - Friday		
	sugars.				patients with blood sugars out		
					the ordered parameters. The i	eview	
	!						

000160

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155258	A. BUIL	DING	00	06/23/2	
		133230	B. WING		PRINCE OF THE COLUMN	00/23/2	J 11
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
COUNTR	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY	205 MARINE DRIVE ANDERSON, IN46016				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	Т	ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	On 6/22/11 at 8:5	50 a.m., during interview,			will occur for 100% of patients		
	the Director of Nursing indicated she was		accuchecks for one month, then				
	unable to locate t	the physician notification			weekly for the next month, then monthly for the next ten months		
	and the facility sl	hould follow the			total twelve months of monitori		
	physician's call p	arameters.			Any identified concerns will be	g.	
					addressed immediately. The res	sults	
	An undated police	y titled "Diabetes			of these reviews will be reported		
	•	Care" was provided by			the Quality Assurance Committee	ee.	
		fursing on 6/22/11 at 9			V. Completion date: 7/23/2011		
	a.m., and deemed				v. Completion date. 1/23/20	'''	
	u.iii., uiid deeiiiee	a do Carrent.					
	The policy indica	ated: "An abnormal lab					
		must be called to the					
	physician"	must be carred to the					
	physician						
	2.1.5(a)						
	3.1-5(a)						
F0167		right to examine the results survey of the facility					
SS=C		eral or State surveyors and					
		tion in effect with respect to					
	the facility.						
							l
		nake the results available and must post in a place					
		to residents and must post					
	a notice of their av						l
		review and interview, the	F0	167	F167 I. The survey results for	r the	07/23/2011
		ensure the most recent			previous 12 months have bee		
	,				placed in the survey book in	the	

l i '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155258	B. WIN	IG		06/23/20)11
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	RINE DRIVE		
COUNTR	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		ANDER	SON, IN46016		
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TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	_	ere available for review			main lobby. II. No residents have been affected. III. The		
	for 4 of 4 survey	days. The deficit			systemic change will be that	the	
	practice had to pe	otential to impact 92 of			survey book will be reviewed		
	92 residents residents	ling in the facility.			scheduled basis to ensure th		
					results of surveys for the pre 12 months are in the survey		
	Findings include	:			IV. The Administrator/Desi	ignee	
	On 6/20/11 at 10	:15 a.m., the Survey		will review the survey book once a week for 30 days, then			
	Book located at t	the reception desk was			bi-monthly for the next month		
	reviewed. The b	ook had the last annual			then monthly for the remainir		
	and post survey i	re-visit included dated			ten months, to total 12 month monitoring. Any identified	ns of	
	5/27/10 and 7/8/	10. The last complaint			concerns will be addressed		
	survevs which w	ere completed on			immediately. The results of t	these	
	_	and 11/30/10, were not			reviews will be forwarded to		
	· ·	ook. On the subsequent			Quality Assurance Committe		
		ey June 21, 22, and 23,			Completion date: 7/23/2011	.	
	-	aint surveys were not in					
	the book.	mit surveys were not in					
	the book.						
	On 6/23/11 at 8·3	30 a.m., the Administrator					
		e complaint surveys were					
		During interview at that					
		ed they should be in the					
		•					
		ought someone had placed					
	them in the book	•					
	3.1-3(b)(1)						
	J.1 - J(U)(1)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155258		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/23/2011		
	PROVIDER OR SUPPLIER	EALTH & LIVING COMMUNITY	•	205 MA	ADDRESS, CITY, STATE, ZIP CODE RINE DRIVE RSON, IN46016		
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F0176 SS=D	drugs if the interdiction by §483.20(d)(2)(ii) practice is safe. Based on observation record review, the aresident was as self-administration medications for 2 receiving respirarisample of 19. (Resident #51 and Findings include 1. On 6/20/11 at #51 was observed treatment in her in was observed presame time during who was standing indicated she was into the resident's her task with the Resident #51's refo/21/11 at 1:30 p diagnoses include chronic obstruction and asthma.	2 of 4 residents observed tory medications in a d #32) 12:20 p.m., Resident d receiving her nebulizer room. No nursing staff esent in the room. At this g an interview, LPN #9, g at the nurse's station, s planning on going back is room as she finished	F0	176	F176 I. Patient # 51 and #32 have be assessed for self administering respiratory medications. 1:1 education has been provided to #9 on self administration of respiratory medications. II. Patients with current orders respiratory medications were assessed for self administration Patients who are assessed to be capable of self administering the own respiratory medications, whave their M.D. notified and rethat an order be given for them able to self administer their respiratory medications. III. The systemic change will include the self administration of medication assessment to be in in all new admission assessment residents with respiratory inhalm. The self administration of medications assessment will also become a routine assessment with each Minimum Data Set for those residents with respiratory inhalm. Training will be provided to lic nurses for the completion of the administration of medications assessments. Training will also include proper technique and tiframes of handheld inhalers as	for for eeir rill quest to be of cluded ats for eers. ecation eers. ensed e self ome	07/23/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155258	B. WIN			06/23/2011
			B. WEN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				RINE DRIVE	
	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY			SON, IN46016	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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	(to aide in respiratory function) use				as patient education for their use	ð.
	contents of one v	vial per nebulizer 4 times			IV. Medication pass observation	one
	a day.				will be conducted four times pe	
					week with licensed nurses for	
	No information v	was indicated concerning			administration of respiratory	
	a self medication	assessment and/or			medications for one month, then	
	physician order t	o self administer			weekly for the next month, then	
	medication.				monthly for the next ten months total twelve months of monitori	
					Any identified concerns will be	ug.
	2. On 6/22/11 from 8:05 a.m. to 8:35 a.m., medication pass was observed.				addressed immediately. The res	sults
					of these reviews will be reported	
		ner medications, LPN #9			the Quality Assurance Committ	ee.
	1 1 0	hand Resident #32 her				
		aler (to aide in respiratory			V. Completion date: 7/23/2011	
		PN #9 entered the				
	<i>'</i>					
		h her hands, the resident				
		administer 1 puff by				
		by a quick second puff.				
		ned to the bedside, she				
		#32 her Spiriva Inhaler				
		atory function), which				
		be administered by the				
	resident. No inst	tructions were given to				
	the resident as sh	e took her respiratory				
	medications.					
	Resident #32's re	ecord was reviewed on				
	6/20/11 at 3:10 p	.m. The resident's				
	_	ed, but were not limited				
	_	ongestive heart failure,				
	_	and acute chronic				
	•	onary disease with				
	hypoxemia.	onary disease with				
	пуроленна.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155258	B. WIN			06/23/2	011
		<u> </u>	1		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		205 MA	RINE DRIVE		
COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				SON, IN46016			
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TAG	 		-	TAG	DEFICIENC!)		DATE
	1 ^ *	rder, dated 5/12/11, were					
	1	er 180 micrograms inhale					
	1 ^	y and Spiriva capsule					
	handinhaler inha	ale contents of 1 capsule					
	by mouth once daily.						
	No information	was indicated related to a					
		assessment and/or					
	physician order.	assessment und/or					
	physician order.						
	On 6/22/11 at 2:12 p.m. during an						
	interview, the Director of Nursing						
	indicated Resident #32 did not have an						
	assessment for a						
		ntil it was completed					
		itti it was completed					
	today.						
	3. The "Self-Ad	lministration of Drugs"					
	1	ided by the Director of					
	1 ^ ^	/11 at 2:15 p.m. This					
		dicated the following:					
	current poncy in	dicated the following.					
	"Policy Statemen	nt					
	Residents in our	facility who wish to					
	self-administer t	heir medications may do					
	1	nined that they are capable					
	of doing so.						
	Policy Interpreta	ation and Implementation					
	1 -	eir overall evaluation, the					
	staff and practiti	oner will assess each					
	resident's mental	l and physical abilities, to					
	determine wheth	ner a resident is capable of					

000160

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155258	(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY PLETED (2011
	PROVIDER OR SUPPLIER	EALTH & LIVING COMMUNITY	205 MA	ADDRESS, CITY, STATE, ZIP CO RINE DRIVE RSON, IN46016	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
TAG	self-administerir3. If the staff of cannot safely self the nursing staff resident's medical the "MEDICAT ADMINISTRAT POLICIES & PF was provided by on 6/22/11 at 2:1 policy indicated "Administration11. Residents self-administer a specifically auth	determine that a resident f-administer medications, will administer the ations" ION TION: GENERAL ROCEDURES" policy the Director of Nursing 5 p.m. This current the following: are not allowed to my medication unless orized to do so by the team (IDT) and the	TAG	DEFICIENCY		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155258		(X2) MU A. BUILI B. WING	DING	OO	(X3) DATE S COMPL 06/23/2	ETED	
	PROVIDER OR SUPPLIER	EALTH & LIVING COMMUNITY	p. wiito	STREET AI	DDRESS, CITY, STATE, ZIP CODE RINE DRIVE SON, IN46016		
COUNTF (X4) ID PREFIX TAG F0177 SS=D	SUMMARY S (EACH DEFICIEN REGULATORY OR An individual has to another room we purpose of the transident of a SNF, institution that is an institution that is an NF, from the distinction is a SNF. A resident's exercit transfer under particles and affect the entitlement to Medicare in the second of the second o	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) The right to refuse a transfer ithin the institution, if the insfer is to relocate a from the distinct part of the SNF to a part of the ot a SNF, or a resident of a lect part of the institution that it pa		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	record review, the residents where redifferent area of resident became services for 1 of room transfers in (Resident #46) Findings include Resident #46's red6/20/11 at 11:05 current diagnoses limited to, depresdiabetes mellitus Resident #46 had Transfer Notice" "Resident request plans to stay long	ccord was reviewed on a.m. Resident #46's s included, but were not ssion, hypertension and	F01		I. Resident #46 has been interviregarding her agreement with curoom placement. As room preference becomes available, the resident will be moved if necess. II. Intra-facility transfers from the last 30 days have been identified. Residents identified will be interviewed regarding their agreement with current room placement. III. The systemic change include that intra-facility transfers will be provided only when voluntary, when necessary to meet the residents' needs. Education has been provided to Social Services regarding prope intra-facility transfers only when voluntary or when necessary to the residents' needs. IV. The administrator or design will review the intra-facility transfers.	the dary. the dary. des de	07/23/2011

000160

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155258	B. WING			06/23/2011	
			D. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			RINE DRIVE		
COLINTE	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY			SON, IN46016		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	1	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION	
TAG			+	TAG			DATE
	the 300 hall to the	ne 200 hall.			form for verification of reason f	or	
					each transfer.		
	During a 6/23/11, 10:10 a.m., interview				Any identified concerns will be		
	1	6's family member, who			addressed immediately. The re-		
		regarding the residents			of these reviews will be reporte the Quality Assurance Committ		
		member indicated,			are Quarity Assurance Committee		
	1	•			V. Completion date: 7/23/201	l.	
		d changed rooms from the			1		
		00 hall "because she was					
		ring rehab services and					
	would become a	permanent patient and					
	they (the facility) do not take medicaid on					
	that side (300 ha	ll) of the building. They					
	keep it (the 300 l	,					
	Davious of a 6/20	0/11, facility completed					
	1	form indicated the					
	1 *	licensed beds. All 109					
	beds were dually	certified indicating					
	residents who re	sides in those beds could					
	have their stay p	aid for by, Medicaid,					
		e pay and/or private					
	insurance as app						
	пізаганее из арр	1104010.					
	Davious of a assess	eant facility booklat titled					
		rent facility booklet titled					
	1	anor Health & Living					
	· ·	de to Community					
	Living", which w	vas provided by the					
	Administrator or	n 6/20/11 at 10:35 a.m.,					
	indicated the following	lowing:					
	"Transitional Ca	re Unit Agreement					
		determine that you would					
	1						
		itional long-term services					
	upon competition	n of your short term					

STATEMEN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155258	B. WIN			06/23/2	011
NAME OF I	PROVIDER OR SUPPLIER)		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUPPLIER			205 MA	RINE DRIVE		
COUNTR	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		ANDER	RSON, IN46016		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
	· ·	conference will be held to					
		eds. At that time, you					
		ed to a suitecreate a					
		atmosphere for your					
		. This discussion will					
	1 ^	imum of 24-hours prior to					
	the end of your r	rehabilitation stay."					
	During the initia	l tour and initial					
	~	ne facility on 6/20/11 at					
		00 unit had carpeted halls,					
		n the resident rooms.					
	_	had multicolored green,					
		dy fall colored matching					
	bed spreads and	_					
	_	rative framed art in the					
	l '	eme and synthetic wood					
		mately 90% of the rooms					
		tyle television(s) either					
		wall or on a stand.					
		1, 12:45 p.m. interview,					
		or indicated the flat screen					
		e 300 hall resident rooms					
	were provided by						
	TOTO PROVIDED O	j and inclinity.					
	The 200 unit had	d cream flecked tiled					
	floors in the hall	way and resident rooms.					
	The hallways we	ere tan/taupe and cream.					
	Resident rooms	varied in color with					
	non-matching be	edspreads and window					
	I -	ne rooms did not have any					
		nts and had blinds only.					
		ted to have flat screen					
	televisions. Dur	ing a 6/23/11, 12:45 p.m.					

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155258	B. WING			06/23/20	011
	PROVIDER OR SUPPLIER	EALTH & LIVING COMMUNITY		STREET A	ADDRESS, CITY, STATE, ZIP CODE RINE DRIVE SON, IN46016		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0223 SS=A	facility had not p the 200 hall resided 3.1-12(a)(14) The resident has the verbal, sexual, phycorporal punishment seclusion. The facility must not sexual, or physical punishment, or inverbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal for 1 of 7 resident prevention in a set where the facility failed free from verbal free free from verbal free free from verbal free from verbal free free free free free free free fre	he right to be free from ysical, and mental abuse, ent, and involuntary ot use verbal, mental, labuse, corporal yoluntary seclusion. ew and record review, lato ensure residents were abuse and intimidations ats reviewed for abuse ample of 19 (Resident esidents reviewed for in a supplemental ident #200).	F02	223	F223 I. C.N.A. #15 and C.N.A. #18 of terminated from employment following the investigated abuse allegations. Resident #200's far and MD were notified. Resident #200 was assessed for physical emotional harm and found to be without injury or distress. Resident #60 was assessed for physical and emotional harm and found to be without injury or distress. The facility followed in policy for the investigation of all II. Other resident interviews we conducted with no concerns identified.	e mily nt and e and its' buse.	07/23/2011
	, ,	•					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155258		LDING	00	06/23/2011
		100200	B. WIN		A DDDEGG CITY GTATE ZIR CODE	00/20/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE RINE DRIVE	
COUNTR	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		1	SON, IN46016	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
IAG		LSC IDENTIFYING INFORMATION)	-	IAG	III. The facility will continue to	DATE
		/11, "Facility Incident dicated the following:			follow its' policy for the	
	Report Form in	incated the following.			investigation of abuse.	
	 "Visitor witnesse	ed staff member reacting			TT D 11 . 1 . 1	
		o patient [Resident #200]			IV. Residents interviews are conducted to gauge resident	
		ventive measures taken:			satisfaction. Any concerns iden	ntified
	Staff member sus				through this process are followed	
		vestigation2/28/11:			on immediately.	
	Staff member [C	•			V. Completion date: 7/23/2013	1
	terminated."	•			7. Completion date: 7/25/2015	
	Review of a, 2/2	3/11, facility "Resident				
	Abuse Report Fo	rm Initial Report"				
	indicated the foll	owing:				
	IIIDa ata da nama a	abaamad dha CNIA [#15]				
	"	observed the CNA [#15]				
		tient's] [Resident #200's] point her finger @ her				
		dent #200's] upper				
		after] pt voiced need to				
		mThe employee				
	-	mmediately removed				
	-	area, interviewed,				
	suspended and se					
	Review of a, 2/2	3/11, "Accident				
	Investigation For	m Unusual Occurrences"				
	indicated the foll	owing:				
	"Staff Member					
		sident #200] needing to				
	"	throom] CNA [#15] said				
	I -	& started to take pt out of				
	room & pt grabb	ed the door the CNA then				

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155258	- 1	LDING	00	COMPL 06/23/2	
		100200	B. WIN		A DDDEGG CITY CTATE 7ID CODE	00/20/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE RINE DRIVE		
COUNTF	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		1	SON, IN46016		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	πE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1 *	on the patient's [hands]					
	*	of the door brought her					
	into the room &	toileted her.					
	Pt [Resident #2	200] is non verbal but					
	understands. She	e confirmed that the CNA					
	[#15] shook her s	shoulders & pointed her					
	finger @ her tou	ching her shoulder &					
	upper chest area.	"					
	The report indica	atad:					
		rator was notified					
	immediately	rator was notified					
	1	involved, additional					
	l '	ff were interviewed.					
		s family and physician					
	were notified	s family and physician					
		was assessed for physical					
	l '	arm and found to be					
	without injury or						
	"	mber involved was					
	l ′	ng investigation and					
		ving the investigation.					
		ollowed it's policy for the					
	investigation of a	1 2					
	· -	oyees were re-educated					
	to prevent future	-					
	2 Danish at #601						
		s record was reviewed on					
	1	.m. Resident #60's					
		s included, but were not					
	· ·	ic renal failure and					
	dementia.						

000160

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155258		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPL 06/23/2	ETED	
		155256	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/23/2	011
NAME OF F	PROVIDER OR SUPPLIER			205 MA	RINE DRIVE		
		ALTH & LIVING COMMUNITY		ANDER	SON, IN46016		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAU	Review of a 5/14 Reporting Form" "On the morning overheard C.N inappropriate wit careInvestiga involved was ver resident and this terminated." Review of an und association to the above event titled regarding the inc following: LPN #10: Stated yelling at [Reside she [LPN #10] we dees calating the stated that [CNA her behavior and [CNA #8] got rig face and was yell #8] was using incomplete.	/11, "Facility Incident indicated the following: of 5/14/11, facility staff A. being verbally he resident during AM tion showed that C.N.A. bally inappropriate with staff member was dated form provided in envestigation of the definition of the		IAU			DATE
		[CNA #8] go into room. Her heryelling "					

NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DRIVE ANDERSON, IN46016 (X5)		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155258	A. BUILDI		NSTRUCTION 00	(X3) DATE S COMPL 06/23/2	ETED
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CNA #12: "Was in the room next door. She stated that she heard [CNA #8] yell at [Resident #60] 'I'm late today. I can't f				2	205 MAF	RINE DRIVE	1 00/20/2	
She stated that she heard [CNA #8] yell at [Resident #60] 'I'm late today. I can't f	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
here to get you fing up. I'm sorry that I was fing late.' " Social worker #14: "I was walking outside [room number] when I heard [CNA #8] yelling in [Resident #60's room]. I heard her say 'I'm not dealing with this fing s t today. I'm not dealing with your attitude today.' [CNA #8] came out of the room and yelled 'This place is fed up.' " The report indicated: a.) The administrator was notified immediately b.) The resident involved, additional residents and staff were interviewed. c.) The resident's family and physician were notified d.) The resident was assessed for physical and emotional harm and found to be without injury or distress. e.) The staff member involved was suspended pending investigation and terminated following the investigation. f.) The facility followed it's policy for the investigation of abuse or neglect. e.) Current employees were re-educated to prevent future abuse.		She stated that she [Resident #60] 'I -ing(couldn't mere to get you family for the state of t	the heard [CNA #8] yell at a make out last part). I'm and the out last part). I'm and the out last part). I'm are-ing up. I'm sorry that I are ing up. I'm not are attitude today. I'm not are attitude today. I'm not are attitude today. I'm not are interested involved, additional are involved, additional are involved, additional are involved. In and found to be a distress. In the investigation and are involved was an investigation and wing the investigation. In the investigation are involved it's policy for the abuse or neglect. In loyees were re-educated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED			
		155258	B. WING		06/23/2011	
	PROVIDER OR SUPPLIER	EALTH & LIVING COMMUNITY	205 MA	ADDRESS, CITY, STATE, ZIP CODE RINE DRIVE RSON, IN46016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
mo	Review of a curritiled "Abuse Preprovided by the Aat 10:25 a.m., incomment that sexual, physical, corporal punishmaseclusion" During a 6/20/11 the Administrato	ent 4/2011, facility policy evention", which was Administrator on 6/20/11 dicated the following: resident with an are is free from verbal, and mental abuse, ment, and involuntary , 9:30 a.m., interview, r indicated both CNA were terminated from owing the above				
F0282 SS=E	facility must be pro in accordance with plan of care.	ided or arranged by the by dead by qualified persons an each resident's written review, observation and	F0282	F282	07/23/2011	
	interview, the factorial plan of care was application of The Deterrent Hose (cility failed to ensure the	FU282	I. Patient # 24's information regarding T.E.D hose has been placed on the C.N.A. assignment sheet. Patient # 6 orthostatic blursing measure. Patient # 32 accuchecks at 11am and HS have	nt ood per	

IDENTIFICATION NUMBER: 155258 Name 00 COMPLETED 06/23/2011	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY ANDERSON, IN46016 STREET ADDRESS, CITY, STATE, 7IP CODE 205 MARRINE DRIVE ANDERSON, IN46016 ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE ADDRESS, CITY, STATE, ZIP CODE 205 MARRINE DRIVE ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION WILST BE RECIDED BY PLIL ANDERSON, IN46016 CACH DEFECTION SHAPE DRIVE ANDERSON, IN46016 CACH DEFECTION WILST BE ADDRESS. CITY, STATE, ZIP CODE CACH DEFECTION WILST BE ADDRESS. CITY, STATE, ZIP CACH ANDERSON, IN46016 CACH DEFECTION WILST BE ADDRESS. CITY, STATE, ZIP CACH ANDERSON, IN46016 CACH DEFECTION WILST BE ADDRESS. CITY, STATE, ZIP CACH ANDERSON, IN46016 CACH DEFECTION WILST BE ADDRESS. CITY, STATE, ZIP CACH ANDERSON, IN46016 CACH DEFECTION WILST BE ADDRESS OF CACH AND FROM THE ADDRESS OF COMPLETION DATE OF COMPLETION BACK BOOK AND THE ADDRESS OF COMPLETION DATE OF CACH AND THE ADDRESS OF COMPLETION BACK BOOK	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DRIVE COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LS. DIENTIFYSTING INFORMATION) and sliding scale insulin (Resident # 6, # 32, # 30, # 48 and #51) and completion of labs (Resident #30 and #60) for 7 of 19 residents reviewed for following the plan of care in a sample of 19. Findings include: 1. The record for Resident # 24 was reviewed on 6/20/11 at 11:30 a.m. Current physician orders for June 2011 indicated an order for TED hose to be on the right leg in the a.m. and off in the p.m. The original date of order was 5/10/11 indicating the resident had right lower extremity edema. On 6/20/11 at 10:50 a.m., during a dressing change observation, the resident was observed being transferred to bed and did not have a TED hose on his right leg. At that time, during interview, CNA # 1 indicated the fid not have a TED hose was not on the assignment sheet. STREETA DDRESS, CITY, STATE, ZIP CODE 205 MARINE DRIVE ANDERSON, IN46016 (X5) DREFIX TAG BROUNDING ANDERSON, IN46016 (X5) DATE TAG BROUNDING ANDERSON, IN46016 (X5) DATE DEMONDING ANDERSON, IN46016 DATE Deen placed on a medication error report with family and MD notification. Resident #30 no longer resides at this community. Patient # 51 and patient # 48 sliding scale insulin administration Record (M.A.R.) and will be administration Record (M.A.R.) a			155258	1			06/23/2011	
COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY YULL AGE (EACH DEFICATION SUBLIDED. BASICINETY AND YOUR AGE (EACH HILL) AGE (EACH H				D. WII.		ADDRESS CITY STATE ZIP CODE		
COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY IX4 ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) and sliding scale insulin (Resident # 6, # 32, # 30, # 48 and #51) and completion of labs (Resident #30 and # 60) for 7 of 19 residents reviewed for following the plan of care in a sample of 19. Findings include: 1. The record for Resident # 24 was reviewed on 6/20/11 at 11:30 a.m. Current physician orders for June 2011 indicated an order for TED hose to be on the right leg in the a.m. and off in the p.m. The original date of order was 5/10/11 indicating the resident had right lower extremity edema. On 6/20/11 at 10:50 a.m., during a dressing change observation, the resident was observed being transferred to be dand did not have a TED hose on his right leg. At that time, during interview, CNA # 1 indicated he did not have a TED hose on. She then checked her CNA assignment sheet and indicated TED hose was not on the assignment sheet. A the same of the received a signment sheet and indicated TED hose was not on the assignment sheet. DID PROVIDENT ALL OF COMPLETION COMPLETION COMPLETION TAG DATE DEPONITION TAG REGULATORY OF USE CIENTIFY IN INFORMATION) TAG DEPONITION TAG REGULATORY OF USE CIENTIFY IN INFORMATION) TAG Deen placed on a medication error report with family and MD. notification. These patients sliding scale orders have been clarified on the Medication Administration Record (M.A.R.) and will be administered as ordered. Patient # 60 and # 30's laboratory errors were placed on a medication error report with family and MD. notification. These patients sliding scale orders have been clarified on the Medication Administration Record (M.A.R.) and will be administered as ordered. Patient # 60 and # 30's laboratory errors were placed on a medication error report with family and MD. notification. There were no negative resident outcomes resulting from the above errors. II. Orders have been reviewed to identify patients requiring ted hose. This information has	NAME OF I	PROVIDER OR SUPPLIER						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) and sliding scale insulin (Resident # 6, # 32, # 30, # 48 and # 51) and completion of labs (Resident #30 and # 60) for 7 of 19 residents reviewed for following the plan of care in a sample of 19. Findings include: 1. The record for Resident # 24 was reviewed on 6/20/11 at 11:30 a.m. Current physician orders for June 2011 indicated an order for TED hose to be on the right leg in the a.m. and off in the p.m. The original date of order was \$/10/11 indicating the resident had right lower extremity edema. On 6/20/11 at 10:50 a.m., during a dressing change observation, the resident was observed being transferred to bed and did not have a TED hose on. She then checked her CNA assignment sheet. PREFIX TAG Begruincy Action steadcation error report with family and MD notification. Resident #30 no longer resides at this community. Patient # 51 and patient # 48 sliding scale insulin administration has been placed on a medication error report with family and MD. notification. These patients sliding scale orders have been oreviewed any ordered. Patient # 51 and patient # 48 sliding scale insulin administration has been placed on the Medication Administration Record (M.A.R.) and will be administered as ordered. Alm with family and M.D. notification. These patients sliding scale orders have been reviewed to identify patients requiring ted hose. This information has been added to the C.N.A. assignment sheet. Current patients with orthostatic blood pressures have been reviewed. Any identified concerns have been addressed. Current patients with accucheke orders have been reviewed. Any identified concerns have been reviewed and are on the M.A.R. to be received as ordered. Residents receiving sliding scale type insulins have had their M.A.R. sclarified and are preciving medication as ordered.	COUNTR	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		1			
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did not have a TED hose on his right leg. At that time, during interview, CNA # 1 indicated he did not have a TED hose on. She then checked her CNA assignment sheet and indicated TED hose was not on the assignment sheet. pressures have been reviewed. Any identified concerns have been addressed. Current patients with accucheck orders have been reviewed and are on the M.A.R. to be received as ordered. Residents receiving sliding scale type insulins have had their M.A.R.s clarified and are receiving medication as ordered.						_	urrent	
At that time, during interview, CNA # 1 indicated he did not have a TED hose on. She then checked her CNA assignment sheet and indicated TED hose was not on the assignment sheet. identified concerns have been addressed. Current patients with accucheck orders have been reviewed and are on the M.A.R. to be received as ordered. Residents receiving sliding scale type insulins have had their M.A.R.s clarified and are receiving medication as ordered.			_			_		
At that time, during interview, CNA#1 indicated he did not have a TED hose on. She then checked her CNA assignment sheet and indicated TED hose was not on the assignment sheet. addressed. Current patients with accucheck orders have been reviewed and are on the M.A.R. to be received as ordered. Residents receiving sliding scale type insulins have had their M.A.R.s clarified and are receiving medication as ordered		did not have a Tl	ED hose on his right leg.				Any	
Indicated he did not have a TED hose on. She then checked her CNA assignment sheet and indicated TED hose was not on the assignment sheet. accucheck orders have been reviewed and are on the M.A.R. to be received as ordered. Residents receiving sliding scale type insulins have had their M.A.R.s clarified and are receiving medication as ordered.		At that time, dur	ing interview, CNA # 1				h	
She then checked her CNA assignment sheet and indicated TED hose was not on the assignment sheet. reviewed and are on the M.A.R. to be received as ordered. Residents receiving sliding scale type insulins have had their M.A.R.s clarified and are receiving medication as ordered.		indicated he did	not have a TED hose on.				.11	
sheet and indicated TED hose was not on the assignment sheet. be received as ordered. Residents receiving sliding scale type insulins have had their M.A.R.s clarified and are receiving medication as ordered		She then checked	l her CNA assignment			1	. to	
the assignment sheet. receiving sliding scale type insulins have had their M.A.R.s clarified and are receiving medication as ordered			· ·				l l	
have had their M.A.R.s clarified and							I	
2 The record for Resident # 6 was							• • • • • • • • • • • • • • • • • • •	
		2 The record for	r Pasidant # 6 was			are receiving medication as ord	ered.	
. 1 (20/11 + 2.22								
reviewed on 6/20/11 at 2:30 p.m. Current III. The systemic change is that			-					
diagnoses included, but were not limited during the daily review of physician and the Many (Many day through Friday) if a		"	ea, but were not limited				I	
to, hypotension. orders (Monday through Friday), if a patient receives an order for T.E.D.		to, hypotension.						
hose, this information will be placed							I	
The nursing notes for 5/22/11 indicated on the C.N.A. assignment sheet		The nursing note	s for 5/22/11 indicated					
the resident had a fall and went to the		the resident had	a fall and went to the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155258		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/23/2011
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MANOR HE	ALTH & LIVING COMMUNITY	205 MA	ADDRESS, CITY, STATE, ZIP CODE ARINE DRIVE RSON, IN46016	
PREFIX (EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
emergency room returned to the fa An order dated 5/ for orthostatic blot then standing blo completed for 3 c The May 2011 M Record (MAR) in pressure was taked Additional inform from the Director at 4:45 p.m., regal orthostatic blood On 6/22/11 at 8:5	for evaluation and cility. (23/11 indicated an order pod pressures (sitting od pressure checks) to be lays. (edication Administration adicated a single blood en on 5/23/11-5/25/11. (anation was requested of Nursing on 6/21/11 arding the lack of pressures. (b) a.m., during interview,	I	at that time. Any new orders for accuchecks will be reviewed to ensure accurate transcription to MAR/TAR. Orthostatic blood pressures will be documented or "Orthostatic blood pressure for be completed by the licensed may be completed by the licensed may be requisition of accurate insulin dosage. Laboratory requisitions will be completed to include the date that it is to be of if different from our regular lab days. Education will be provided the lab provider, that labs should drawn on next routine draw dat scheduled, unless otherwise not Education has been provided to licensed nursing staff regarding administration of medications a ordered, clarifications of sliding	the on the m" to urse. has ree do drawn drawn draw ed to dd be e ted.
the Director of N orthostatic blood completed for the	pressures were not		scale insulin on the M.A.R., obtaining orthostatic blood pres and procedure for lab requisition	ons.
reviewed on 6/20	•		IV. Medication Administration Records will be audited for slid scale insulin administration and proper transcription of physicia	ling I n
limited to, diabet			orders. C.N.A. assignment she will be audited for addition of appropriate information. Lab requisitions will be audited to e	
indicated an orde completed before Original date of t	orders for June 2011 r for accuchecks to be meals and at bedtime. the order was 5/12/11.		proper lab draw dates. This will reviewed five times per week for month, then weekly for the nex month, then monthly for the ne months, to total twelve months monitoring. Nurse manager or	Il be or one t xt ten

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI	
AND PLAN	OF CORRECTION	155258	A. BUII		00	06/23/20	
		100200	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/20	
NAME OF I	PROVIDER OR SUPPLIER				RINE DRIVE		
COUNTR	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		1	SON, IN46016		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re	COMPLETION DATE
ind	Administration R accucheck results bedtime for May Additional inform 6/21/11 at 4:45 p Nursing regardinaccucheck results On 6/22/11 at 8:5	Record (MAR) lacked s for 11 a.m., and at 13-June 21, 2011. mation was requested on .m., from the Director of g the lack of the above		mo	designee will be responsible. Any identified concerns will be addressed immediately. The re of these reviews will be reporte the Quality Assurance Committ V. Completion date: 7/23/201	sults d to ee.	DATE
	unable to provide accuchecks. 4. Resident #51': 6/21/11 at 1:30 p diagnoses include to, insulin dependent to, insulin dependent to the physician or glucometer (to clude before meals and sliding scale with sugars of 151 - 2 250 = 4 units. The "Medication indicated on 5/13 indicated a blood units of Novolog	e any of the above s record was reviewed on m. The resident's ed, but were not limited dent diabetic mellitus. der, dated 5/10/11, were neck for blood sugars) at bedtime; Novolog the range of blood $00 = 2 \text{ units and } 201 \text{ -}$ Record" for May 2011					
ı		rector of Nursing					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155258	B. WIN			06/23/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RINE DRIVE		
COUNTE	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		I	RSON, IN46016		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	BLI ICILIACI)		DATE
		3/11 at 4:00 p.m. the					
		and received 4 units of					
	insulin coverage	with a blood sugar of					
	205.						
	5. Resident #48'	s record was reviewed on					
		.m. The resident's					
	1	ed, but were not limited					
	to, diabetes melli						
	to, diabetes inclin	itus Type II.					
	701 1	1 1 4 1 4/10/11					
		order, dated 4/13/11, was					
	•	od sugar checks) before					
	meals and at bed	time; Novolog insulin					
	sliding scale with	n the range of blood					
	sugars of 201 - 2	50 = 4 units and blood					
	sugar of 251 - 30						
	The "Medication	Record" for June 2011					
		1/11 at 11:00 a.m. the					
	blood sugar was	251 with 4 units given.					
	0 (100/11) 0	1.5					
		15 a.m. during an					
	· ·	rector of Nursing					
		1/11 at 11:00 a.m. the					
	resident should h	ad received 6 units of					
	insulin coverage	with a blood sugar of					
	251.	-					
	6 Resident #30'	s record was reviewed on					
		.m. The resident's					
	_						
	~	ed, but were not limited					
	to, diabetes melli	itus.					
	The physician's of	order, dated 6/07/11, was					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155258	B. WIN	G		06/23/2011
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	!
					RINE DRIVE	
COUNTF	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		ANDER	SON, IN46016	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
		re meals and at bedtime				
	with Novolog sliding scale with the range					
	of blood sugars of $141 - 240 = 2$ units.					
	The "Medication	Record" for June 2011				
		1/11 at 7:00 a.m. the				
		150 with no insulin				
	coverage given.	130 WILLIO HISUIII				
	Coverage giveil.					
	On 6/22/11 at 8·1	15 a.m. during an				
		rector of Nursing				
	· ·	1/11 at 7:00 a.m. the				
		and received 2 units of				
		with a blood sugar of				
	150.	with a blood sugar of				
	130.					
	7. Resident #60'	s record was reviewed on				
		.m. The resident's				
	_	ed, but were not limited				
	to, congestive he					
	, 8					
	The physician's o	order, dated 5/09/11, was				
	to obtain a comp	rehensive metabolic				
	_	l a complete blood count				
	(CBC) on 5/12/1	*				
	The laboratory st	tudies indicated a CMP				
	and CBC were of	btained on 5/10/11 with				
	no information o	f any laboratory studies				
	were done on 5/1	-				
	On 6/22/11 at 8:4	45 a.m. during an				
	interview, the Di	rector of Nursing				
	indicated the nur	se, who had submitted				

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155258		LDING	00	06/23/2	
		100200	B. WIN		DDDEGG CITY CTATE ZID CODE	00/20/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE RINE DRIVE		
COUNTR	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY			SON, IN46016		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG			-	TAG	DEFECT.)		DATE
	1 ^	n to the lab, had not					
	1 ^ -	he labs were to be drawn.					
	This resulted in the labs being drawn on 5/10 instead of 5/12 as ordered.						
	8. Resident #30's	s record was reviewed on					
	6/22/11 at 2:25 p.m. The resident's						
	diagnoses include	ed, but were not limited					
	to, congestive he	art failure, chronic					
	obstructive pulmonary disease, anemia, hyperlipidemia, and hypertension.						
	1	der, dated 6/01/11, was to					
	`	omplete blood count) due					
	· ·	(Basal Metabolic Panel)					
		of breath, magnesium					
	level, and liver p	rofile due to					
	hyperlipidemia.						
	No laboratory stu	idies were completed on					
	6/01/11.	•					
		progress notes, dated					
	1	d labs were not obtained					
	on 6/03/11 as ord	lered.					
	On 6/23/11 at 12	:35 p.m. during an					
		rector of Nursing					
	· ·	oratory orders were					
		shift and were left for the					
	evening nurse to						
	_	ition. This was done at					
		e same day but was too					
	_	ab day's scheduled blood					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	ILTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL	
THIND I LIMIT	or connection	155258	A. BUIL			06/23/2	
	ROVIDER OR SUPPLIER	ALTH & LIVING COMMUNITY	B. WINC	STREET A	ADDRESS, CITY, STATE, ZIP CODE RINE DRIVE SON, IN46016		
(X4) ID		TATEMENT OF DEFICIENCIES	\perp	ID			(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	COMPLETION DATE
F0309 SS=D	draw (6/03/11) redrawn on 6/06/11 nurse receiving flashould be completed requisition order 3.1-35(g)(2) Each resident must must provide the nurse provide the nurse accordance with assessment and passed on record facility failed to emedication was a nausea, (Resident ensure a resident assessed for comfor 3 of 3 resident appropriate admit	esulting in the labs being She also indicated the me laboratory orders eting the laboratory and faxing it to the lab. Streceive and the facility and faxing it to the lab. Streceive and services in the highest practicable and psychosocial well-being, at the comprehensive lan of care. The review and interview, the ensure a one time administered timely for the street the diministered to with hyperglycemia was plications (Resident # 6) the reviewed for mistration of medication and interviewed in sample of 19.	F03		F309 I. A medication error report has completed for patient #46's omi medication and patient # 6's blo sugar levels outside of the order parameters. Both MD and famil have been notified. MD orders clarified regarding residents #46 #6. II. Patients with nausea sympto have been identified with approassessment as needed. Patients	been tted ood ed y were 6 and	DATE 07/23/2011
	1.) Resident #46's record was reviewed on 6/20/11 at 11:05 a.m. Resident #46's current diagnoses included, but were not limited to, depression, hypertension and diabetes mellitus.				blood sugar parameters have be identified and reviewed for clarification and will be administast ordered. III. The systemic change is that new orders will be read aloud discovered.	en stered	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NUJQ11 Facility ID:

000160

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DING	00	COMPLE	ETED
		155258	A. BUII B. WIN			06/23/20)11
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1	RINE DRIVE		
COLINTE	EVSIDE MANOR HE	EALTH & LIVING COMMUNITY		1	SON, IN46016		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	-	DATE
					the clinical meeting and will be		
	Resident #46 had	d a, 6/21/11, physician's			evaluated by the clinical team.		
	order for "phenegran 25 mg (an				orders will be verified by the Unit Manager daily (Monday through		
	anti-nausea medication) IM				Friday).	311	
	(intramuscular injection) 1 dose for				i ilday).		
	nausea."				IV. Unit Manager/designee wi	11	
	Resident #46 had a, 5/9/11, upper endoscopy report which indicated the resident had an esophageal ring, hiatus hernia and reflux esophagitus.				audit new nausea and blood sug		
					orders daily (Monday through		
					Friday) for one month, then we	-	
					for one month, then monthly for		
					next ten months, to total twelve	•	
					months of monitoring.		
					Any identified concerns will be		
	During a 6/22/11	1, 8:15 a.m. interview,			addressed immediately. The re of these reviews will be reported		
	Resident #46 ind	licated she was suppose			the Quality Assurance Commit		
		r nausea yesterday and			the Quanty Assurance Commit		
	had not gotten it	-			V. Completion date: 7/23/201	1.	
	nad not gotten it	•			•		
	Dagidant #46 ha	d a 6/22/21, 8:34 a.m.,					
	_	ich indicated it was a late					
	1 *	at 8:00 a.m. The note					
		1/11 the resident had a					
	small amount of	emesis and complained					
	of nausea.						
	During a 6/22/11	1, 9:00 a.m., interview,					
	"	ursing indicated Resident					
		n given her 1 time dose of					
		g yesterday 6/21/11 when					
	^	The Director of Nursing					
		· ·					
		ident would receive the					
	injection as soon	as possible.					
	_	1, 2:30 p.m., interview,					
	Resident #46 inc	licated she had received					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		ONSTRUCTION 00	(X3) DATE S COMPL	ETED
		155258	B. WIN			06/23/2	011
	PROVIDER OR SUPPLIER	EALTH & LIVING COMMUNITY	-	205 MA	ADDRESS, CITY, STATE, ZIP CODE RINE DRIVE SON, IN46016		
		TATEMENT OF DEFICIENCIES					(7/5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	her injection that	morning after our					
	previous convers	ation and the shot may					
	have helped a litt	tle bit; but she was still					
	experiencing some nausea and vomiting.						
	 2. The record for Resident # 6 was reviewed on 6/20/11 at 2:30 p.m. Current diagnoses included, but were not limited, Diabetes. Current physician orders indicated an order to notify the physician if blood sugar is less than 60 or greater than 350 as 						
	_	re. The original date of					
	the order was 5/1	15/11.					
	The May 2011 M	Medication Administration					
		nd the nursing notes					
	indicated the foll	· ·					
	On 5/24/11 at 8 r	o.m., the residents's blood					
	•	There was no assessment					
	-	umentation on the					
	*	on or blood sugar.					
	1351dOnt 5 Conditi	on or oroom sugur.					
	On 5/29/11 at 4 p	o.m., the resident's blood					
	-	There was no assessment					
	or follow up on t	he blood sugar or					
	resident condition	n. At 8 p.m., the					
	resident's blood s	sugar remained high at					
	379. Again there	e was not follow up					
	assessment or blo	ood sugar.					
	0 (/22/11	15 mm the Din to C					
		15 p.m., the Director of					
	nursing indicated	d with high blood sugars					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NUJQ11 Facility ID:

ity ID: 000160

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155258	B. WING		06/23/2011
	PROVIDER OR SUPPLIER	ALTH & LIVING COMMUNITY	205 M	ADDRESS, CITY, STATE, ZIP CODE ARINE DRIVE RSON, IN46016	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ld be assessed and the ld be rechecked in 15			
F0315 SS=D	assessment, the faresident who enter indwelling catheter the resident's clinic that catheterization resident who is incappropriate treatmurinary tract infectinormal bladder fur Based on record interview, the fact anchored catheter was positioned or possibility of inferesidents with an sample of 19. (R. Findings include 1. The record for reviewed on 6/20.	review, observation, and callity failed to ensure r tubing and drainage bag ff the floor to prevent the ection for 1 of 2 chored catheters in a resident # 32)	F0315	F315 I. Patient #32's foley catheter thas been re-positioned off of the floor. C.N.A. was educated on proper positioning of foley cathetubing and drainage bag. II. Patients with foley catheters been identified and are monitor correct positioning of catheter tubing. III. The systemic change will in that Charge nurses will complet rounds to observe that each fole catheter bag and tubing are	eter have ed for clude e

li ´		(X2) M				DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155258	B. WIN	IG		06/23/20	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
				1	RINE DRIVE		
COUNTR	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		ANDER	RSON, IN46016		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	an order for an ar	nchored catheter.			positioned and handled in a man to prevent urinary tract infection		
					Any issues identified will be	ns.	
	A plan of care dated 4/1/11 indicated the				addressed immediately.		
		nchored catheter and was			Education has been provided to		
	at risk for infection	on. Approaches to the			nursing staff on proper position	ing	
	plan of care inclu	ided, but were not limited			and handling of foley catheter to	ubing.	
	to, do not allow t	he drainage tubing or			IN The Name		
	drainage system	to touch the floor.			IV. The Nurse manager/design will monitor foley catheter tubin		
					and bag positioning four times	~	
	On 6/20/11 at 12	:05 p.m., during a			week for one month, then week		
	transfer observation of Resident # 32, CNA # 1 assisted the resident to sit on the				one month, then monthly for the	-	
					ten months to total twelve mont		
		As the resident sat up the			monitoring. Any identified con		
		r tubing was on the floor.			will be addressed immediately. results of these reviews will be	The	
		aced the anchored			reported to the Quality Assurance	re	
	_	bag on the side lower			Committee.		
		nt's walker. The anchored					
		bag and tubing were			V. Completion date: 7/23/2011	1.	
		or. There was urine in					
	1	the resident was					
		ner wheelchair, the CNA					
	l -	ge bag and tubing on the					
		esident's wheelchair and					
	""	the floor to where she					
		and then placed the					
		the dignity bag on the					
	wheelchair.						
		ation, during interview,					
	the CNA indicate	ed the anchored catheter					
	tubing and draina	age bag should not be on					
	the floor.						
	On 6/20/11 at 3:0)5 p.m., the resident was					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155258			(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/23/2011
	PROVIDER OR SUPPLIER	EALTH & LIVING COMMUNITY	205 MA	ADDRESS, CITY, STATE, ZIP CODE ARINE DRIVE RSON, IN46016	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
		ng room in her anchored catheter tubing under the wheelchair.			
	in her room in he respiratory treatr anchored cathete under the resider	45 p.m., the resident was er wheelchair receiving a ment. The resident's er tubing was on the floor nt's wheelchair. At that as informed the anchored was on the floor.			
	Urinary" was pro Nursing on 6/22/ as current. The p "Purpose The pu to prevent cathet infectionsInfec	y titled "Catheter Care, ovided by the Director of 11 at 9 a.m., and deemed policy indicated: arpose of this procedure is er-associated urinary tract tition ControlBe sure the nd drainage bag are kept			
F0328 SS=D	proper treatment a special services: Injections; Parenteral and en	ostomy, or ileostomy care; e;			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		COMPI			(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155258	B. WIN			06/23/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
COLINITE	OVELDE MANOD LIE			1	ARINE DRIVE		
		EALTH & LIVING COMMUNITY		ANDER	RSON, IN46016		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG			EC		F328		07/23/2011
		review and interview, the	FU)328	I. Resident #32's oxygen is set	to the	07/23/2011
	l *	ensure oxygen was			physician ordered setting. An		
	administered as ordered by the physician				assessment has been completed		
		at's reviewed for oxygen			determine the patients oxygen l	evel	
	administration in	a sample of 19.			needs. The nurse received 1:1 education on the Diagnosis of C	CORD	
	(Resident # 32)				and oxygen administration to su		
	Findings include	:			patients and following MD orde		
					II. Current patients with oxyge	n	
	The record for R	esident # 32 was			orders have been identified and		
	reviewed on 6/20	0/11 at 3:10 p.m. Current			settings verified.		
	diagnoses includ	ed, but were not limited					
	to Chronic Obstr	uctive Pulmonary			III. The systemic change is to r		
	Disease (COPD)	•			communicate the oxygen order the TAR (Treatment Administra		
					Record) for the nurse's reference		
	Current physicia	n orders for June 2011			Licensed nurses have been educ		
	1	er for oxygen at 4 liters by			on oxygen rates to be placed on		
		iginal date of order was			TAR and to follow physician or		
	3/28/11.	-8			for appropriate oxygen liter flow Licensed nurses will also be	W.	
					educated on oxygen use for CO	PD	
	A nursing note da	ated 5/13/11, late entry			patients.		
	T -	cated the resident's					
		ns were 79-80 %. The			IV. Nurse manager/designee w		
	• •	e oxygen was turned up			audit patients' oxygen levels five times per week for one month,		
		liters, then to 8 liters			weekly for one month, the mon		
		ment. The resident's son			for the next ten months to total		
	_	requested the resident be			twelve months of monitoring.		
	_	gency room. The resident			Any identified concerns will be		
		mergency room. A			addressed immediately. The re		
		ed 5/13/11 at 11:31 p.m.,			of these reviews will be reporte the Quality Assurance Committ		
		dent returned from the			and Quanty Assurance Committee		
		iagnoses of pneumonia.			V. Completion date: 7/23/201	1.	
	nospitai witti a ui	iagnoses of pheumoma.					
	Additional inforr	mation was requested					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155258	B. WING		06/23/2011
NAME OF F	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP CODE	
COUNTR	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		RINE DRIVE RSON, IN46016	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE	DATE
		or of Nursing on 6/21/11 arding the increase in the			
	oxygen flow rate	•			
	oxygen now rate.				
	On 6/22/11 at 8:	50 a.m., during interview,			
		Jursing indicated the			
		e should not go above 4			
	''	ent with COPD. She			
	indicated the nurse who had turned up the				
		new and would be			
	educated.				
	educated.				
	The Lippincott Manual of Nursing				
	Practice Handbo	ok Third Edition,			
	indicated on pag	e 212 that "giving a			
	high oxygen con	centration may remove			
	the hypoxic driv	e, leading to			
	hypoventilation,	respiratory			
	decompensation,	, and the development of			
	worsening respir	atory acidosis"			
	3.1-47(a)				
	The feeting .				
F0332 SS=D		ensure that it is free of ates of five percent or			
SS=D	greater.	atos of five percent of			
	~	ations, record reviews,	F0332	F332	07/23/2011
	and interview, th	ne facility failed to ensure		I. LPN's # 4, 5, and RN #6 rec	I
	it was free of a n	nedication error rate of		1:1 education regarding correct procedure for medication	
	5% or greater for	r 3 of 40 opportunities		administration. LPNs #4, 5 and	l RN
	during 2 of 6 nu	rsing staff observed and		# 6 will have medication	
	for 2 of 8 resider	nts observed during		administration observation to	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	155258	A. BUII	LDING	00	06/23/2011
		155256	B. WIN			00/23/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
COLINTE	YSIDE MANOR HE	ALTH & LIVING COMMUNITY		1	RINE DRIVE SON, IN46016	
				L		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
-		The medication error	1	-	determine compliance with poli	
	rate was 7.5 %.	2.1.0 1.1.0 1.1.01			•	
	(LPN #4 and #5)				II. Licensed nursing staff will be	e
	(Resident #'s 83,				observed for medication	
	(Itesiaeiie ii s os,	0 i, and 10)			administration. Any identified in will be addressed immediately a	
	Findings include				re-education will be completed.	•
	i mamgs merade	•			1	
	 1 On 6/20/11 fro	om 4:10 p.m. to 5:00			III. Education will be provided	•
		pass was observed. The			licensed nurses and QMAs rega appropriate medication	rding
	following was ob	-			administration and will include	the
	10110 111111111111111111111111111111111	your vou.			following:	
	a)First LPN #4	was observed to prepare			*The 5 rights of medicat	tion
		edications. These			administration	
		e Xopenex (to treat			*Insulin types and peak *Accurate documentation	
		.25 mg (milligrams)/3 ml			*Accurate documentation	on.
	• /	ule (amp) per nebulizer 4			IV. Assistant Director of	
		pratropium Bromide			Nursing/designee will audit by	
		on (to aide respiratory			observation of medication	
		0.5 mg/2.5 ml 1 vial in			administration five times per we	I
	*	a day. The resident was			for one month, then weekly for month, then monthly for the next	I
		ve the Xopenex per			months, to total twelve months	
		ed by the Ipratropium			monitoring. Any identified con	cerns
		tion per nebulizer.			from audits will be addressed	
	Diominac medical	non per neodnizer.			immediately. The results of these reviews wil	1 ha
	 Resident #83's re	cord was reviewed on			reported to the Quality Assurance	I
		.m. The resident's			Committee.	
	•	ed, but were not limited				
		id chronic obstructive			V. Completion date: 7/23/2011	l.
	pulmonary diseas					
	pannonary discas	(COID).				
	The physician's o	order, dated 6/04/11 at				
	3:00 a.m., was D					
	·	ion) per nebulizer every 6				
	hours while awal					
	Tours willie awar					

000160

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		NSTRUCTION 00	COMPL	LETED
		155258	B. WIN			06/23/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
COLINTE	SASIDE WVNOB HE	EALTH & LIVING COMMUNITY		1	RINE DRIVE SON, IN46016		
					10011, 111110010		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	The physician's o	order, dated 6/04/11 at					
	8:15 a.m., was to	discontinue the Duoneb.					
	The physician's order, dated 6/04/11 at						
	9:00 a.m., was to sent the resident to the						
	1 "	to evaluate and treat.					
	The hospital discharge orders, dated						
	6/09/11, included						
		g 4 times daily per					
	nebulizer. No ph						
	indicated for the Ipratropium Bromide						
	and/or Duoneb. On 6/21/11 at 9:30 a.m. during an						
		Manager #20 indicated					
	· ·	oratropium Bromide					
		ent was discontinued on					
		not reordered after the					
	resident's return	from the hospital on					
	6/09/11.	•					
	1 ′ ′	4 was observed to prepare					
		sulin medication. LPN					
		to obtain 8 units (u) of					
	1	(to regulate blood sugars)					
		injection. At this same					
	time during an in						
	1	k level for this insulin					
		and she felt safe giving it this time as dinner was					
		p.m. The insulin was					
		o the resident at 4:47 p.m.					
	observed given u	o me resident at 4.47 p.m.					
	Resident #84's re	ecord was reviewed on					
	6/22/11 at 2:10 p	.m. The resident's					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NUJQ11 Facility ID:

000160 If continuation sheet Page 34 of 50

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155258		(X2) MU A. BUII B. WIN	LDING	nstruction 00	(X3) DATE : COMPL 06/23/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	! ?	D	STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
COUNTR	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY			SON, IN46016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	to, diabetes.	led, but were not limited					
	The physician's order, dated 4/21/11, was Novolog Injection 100/milliliter inject 8 units subcutaneously 3 times daily before each meal.						
	interview, CNA to serve the room this same time, I observed in her a She was observe	15 p.m. during an #19 indicated she began in trays at 5:40 p.m. At Resident #84 was room with a room tray. Ed to had eaten only her indicated at this time she					
	Resident #48's n indicated the accoblood sugar of 3 coverage. After Novolog insulin in a syringe, LP1	5 was observed to pass nedication. LPN #5 cucheck resulted in a 41 requiring insulin preparing 8 units of (to regulate blood sugars) N #5 was observed to give r insulin coverage at 5:00					
	6/22/11 at 2:20 p diagnoses includ to, Diabetes Mel The physician or	ecord was reviewed on o.m. The resident's led, but were not limited litus Type II. rder, dated 4/13/11, was on 100/milliliter inject					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155258	A. BUI B. WIN			06/23/2011		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				205 MARINE DRIVE ANDERSON, IN46016				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
	subcutaneously per sliding scale; accucheck before meals and at bedtime; blood sugar 301 to 350 = 8 units.							
	On 6/20/11 starting at 5:45 p.m., the first meal tray was observed to be served in the main dining room. On 6/20/11 at 5:53 p.m., Resident #48 did not have her meal tray as she waited in the main dining room. On this same day at 6:10 p.m., Resident #48 was observed to							
	be eating her requested 2 hot dogs.							
	2. The 2010 Nursing Spectrum Drug							
	Handbook indicated Novolog was a short acting insulin. The administration of Novolog was to be given 5 to 10 minutes before a meal if given by the subcutaneous route. The "DIABETIC MELLITUS - ROUTINE CARE" policy was provided							
ı								
	by the Director of Nursing on 6/22/11 at							
	2:15 p.m. This current policy indicated the following:							
	"Purpose: To provide nursing staff with							
	guidelines for implementing care for the							
	resident with diabetes mellitus.							
	Objective: To pr	ovide care that will						
		nt to achieve and or						
	maintain control	of diabetes and to						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155258		A. BUILDING B. WING	00	COM	COMPLETED 06/23/2011	
	PROVIDER OR SUPPLIER	EALTH & LIVING COMMUNITY	205 N	ET ADDRESS, CITY, STATE, ZIP O MARINE DRIVE ERSON, IN46016	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	function safely in MEDICATION Insulin needs to before the schede The "MEDICAT ADMINISTRAT POLICIES & PR was provided by on 6/22/11 at 2:1 policy indicated "POLICY All medication only as prescribe The meal times was administrator or	n its natural environment. No be given 30 minutes uled meal" ION TON: GENERAL ROCEDURES" policy the Director of Nursing 5 p.m. This current the following: s are to be administered to by a physician" were provided by the 16/20/11 at 10:25 a.m. time was indicated as	TAG	DEFICIENCY)		DATE

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155258	B. WING	1110		06/23/20	011
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				RINE DRIVE		
COUNTR	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY			SON, IN46016		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	AG DEFICIENCY)		DATE
F0441 SS=F	Infection Control P a safe, sanitary an and to help preven transmission of dis (a) Infection Control The facility must e Program under wh (1) Investigates, co infections in the fa (2) Decides what p isolation, should be resident; and (3) Maintains a rec corrective actions (b) Preventing Spr (1) When the Infect determines that a	stablish an Infection Control nich it - controls, and prevents cility; procedures, such as e applied to an individual cord of incidents and related to infections.					
	must isolate the re (2) The facility must communicable disclesions from direct their food, if direct disease. (3) The facility must hands after each communicable and a feet a fe	esident. In the street of the					
	Personnel must hat transport linens so infection. A. Based on obsectord review, the infection control in a manner to present the transport of transport of the transport of the transport of transpo	endle, store, process and as to prevent the spread of ervations, interview, and e facility failed to ensure practices were followed event the potential for extions and diseases	F04-	41	F441 I. Residents # 31, 83,84,48,59, 37 and 32 were reviewed and had no signs or symptoms of infection requiring antibiotic use since survey completion.	ive	07/23/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155258	B. WIN			06/23/2	011
NAME OF I	DROVIDED OD GUDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	s		205 MA	ARINE DRIVE		
		EALTH & LIVING COMMUNITY		ANDER	RSON, IN46016		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	,		DATE
	concerning 3 of 3	•			The infection log for June has b		
	(Laundry Aide #	's 16, 17, and 18) for 3 of			completed with room numbers, infection type and date of resolu		
	3 observations of	f personal clothing being			Laundry staff identified were	ution.	
	delivered, and co	oncerning handwashing,			educated on appropriate linen		
	medication hand	ling, and equipment			handling for delivery of persona	al	
	handling during				clothing.		
	-	of 6 nursing staff ((LPN			Nursing staff identified were		
		RN #6) observed for 8 of			educated on hand washing		
	' ' ' ' '				procedure, glove use and appro	•	
	`	dent #'s 31, 83, 84, 48,			infection control practice during	g	
	' ' '	2) observed during			medication pass.		
	1 *	This deficient practice			H N 4 11 4 66	. 1	
	had the potential	to impact 58 of 92			II. No other residents were affect by the deficient practice. A rev		
	residents, who ha	ad the facility launder			of antibiotic use was conducted		
	their personal clo	othing.			no correlation to the deficient	WILL	
	•				practice. Laundry staff were		
	B Based on reco	ord review and interview,			educated on appropriate linen		
		to implement an			handling for delivery of persona	al	
	1				clothing.		
		program which included			Nursing staff were educated		
	tracking, trending	-			regarding hand washing proced	ure,	
		nfectious patterns. This			glove use, linen handling and		
	_	e had the potential to			appropriate infection control pr	actice	
	impact 92 of 92 i	residents.			during medication pass.		
					III. Systemic change includes t	hat	
	Findings include	<u>.</u>			staff were educated on hand wa		
					procedure, glove use and appro	•	
	A. 1. On 6/20/11	l at 5:20 p.m., Laundry			infection control practice during	•	
		served to be passing			medication pass.		
		g from room to room			Identification of trends for infe		
	^				will occur with review of physi		
		llway. The one side of			orders. Trends will be addresse	ed	
		remained opened during			upon identification.		
	this observation.				Laundry staff will pass resident personal clothing with cart clos		
					personal clouding with cart clos	cu.	
	A. 2. On 6/20/11	l at 5:45 p.m., Laundry			IV. The Assistant Director of		
	Aide #17 was ob	served to be passing			2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155258 06/23/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 MARINE DRIVE COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY ANDERSON, IN46016 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Nursing/designee will audit through personal clothing from room to room direct observations of hand washing down the 200 hallway with the one side of procedure, glove use and appropriate the laundry cart remaining open. At this infection control practice during same time during an interview, LA #17 medication pass five times per week indicated the personal clothing should be for one month, once per week for the covered as it was being next month, then monthly for the next ten months, to total twelve transported/delivered to the resident's months of monitoring. Any rooms. She also indicated while passing identified concerns from audits will linen, she would place items on top of the be addressed immediately. cart preventing her from closing the linen The results of these reviews will be reported to the Quality Assurance cart. Several folded items were observed Committee. presently on the top of the covering for the linen cart. V. Completion date: 7/23/2011 A. 3. On 6/21/11 at 7:55 a.m., Laundry Aide #18 was observed to be passing personal clothing from room to room down the 200 hallway with one side of the laundry cart remaining open. A. 4. On 6/20/11 at 11:05 a.m., Resident #30's accucheck was completed by LPN #3. After showing the resident his blood sugar results, LPN #3 was observed to handwash, turn the water off with her wet hand and then, dried her hands. A.5. On 6/20/11 at 12:05 p.m., medication pass was observed. In preparation, LPN #3 was observed to handwash for less than 10 seconds, turn the water off with her wet hand, and then, dried her hands. She then proceeded to administer Resident #31 his prepared

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATI	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMI	PLETED
		155258	B. WING		06/23/	2011
			_	ET ADDRESS, CITY, STATE, ZIP COI	DE	
NAME OF	PROVIDER OR SUPPLIEF	C	205	MARINE DRIVE		
	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		ERSON, IN46016		_
(X4) ID			ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	insulin in his abo	iomen.				
	1	10 a.m. during an				
	1	#3 indicated one should				
		seconds, rinse one's				
	hands, dry them,	and turn the faucet off				
	with paper towel	ls.				
	A 6 On 6/20/1	1 from 1:10 n m to 5:00				
	1	1 from 4:10 p.m. to 5:00				
	1 *	pass was observed. The				
	following was of	oservea:				
	After LPN #4 pr	epared and administered				
	1	nedication of Xopenex (to				
		spasms) followed by the				
	1 ^	tropium Bromide (to aide				
	_	nction), LPN #4 placed				
	the nebulizer adı					
		l medication cup) into the				
	1	e bedside table. No				
		nebulizer's administration				
	1	ed between medications or				
	arter the medical	tions were completed.				
	Then, after LPN	#4 was observed to				
	prepare Resident	t #84's insulin (to regulate				
	blood sugars) me	edication, she				
	1	less than 10 seconds,				
		off with her wet hands,				
		er hands before donning				
	a pair of gloves.	•				
	1	insulin subcutaneously				
		removed her gloves, and				
	1	less than 10 seconds to				
	1					1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155258	A. BUII B. WIN			06/23/2	
	PROVIDER OR SUPPLIER RYSIDE MANOR HE	EALTH & LIVING COMMUNITY	p. wax	STREET A	ADDRESS, CITY, STATE, ZIP CODE RINE DRIVE SON, IN46016		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	complete her task	ζ.					
	Next, LPN #5 was Resident #48's in donning a pair of Resident #48's in subcutaneously in then removed her them in the bathre medication cart as administered the medication, Warfshe exited Reside #59 requested to room. LPN #5 president down the wheelchair towar handwashing or loobserved. A. 7. On 6/20/11 p.m., Resident #3 observed. RN #6 complete the resist her gloves, hands seconds, turn the hand, and then do same time during indicated one show seconds, rinse on hands, and then, the paper towels.	as observed to prepare sulin medication. After a gloves, she administered sulin medication in the abdomen. LPN #5 in gloves disposing of room, returned to her and prepared and resident's oral farin (blood thinner). As ent #48's room, Resident go down to the dining roceeded to wheel the entitle hallway in her reds the dining room. No handgel use was a from 5:00 p.m. to 5:15 go's accucheck was a was observed to dent's accucheck, remove washed less than 5 water off with her wet ried her hands. At this gan interview, RN #6 buld handwash for 30 ge's hands, dried one's turn the water off with					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NUJQ11 Facility ID:

000160

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155258	B. WIN			06/23/2	011
			-		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEF	ę.		205 MA	RINE DRIVE		
		EALTH & LIVING COMMUNITY			SON, IN46016		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAU		LSC IDENTIFYING INFORMATION)	+	IAG	Berielekery		DATE
	1 ^	pass was observed. RN					
	#6 was observed						
		lent #30's insulin in the					
		vas observed to handwash					
		seconds, turned the water					
		hand, and then dried her					
	hands.						
	A. 9. On 6/21/1	1 from 8:30 a.m. to 9:07					
	a.m., medication	pass was observed. In					
	preparation, LPN	N #7 was observed to					
	1	t #37's oral medications.					
	^ ^	rvation, LPN #7 was					
	1 -	ct with her bare finger					
		ing the Ferrous Gluconate					
	1 -	t) tablet and the Vitamin					
	1	edication cup. Also,					
	1 -	-					
	1 ^	olactone (hypertension)					
	l -	medication's cart top,					
	1 -	t off of the medication					
	1 ^ ^	ed it in the medication					
	1 ^	of the oral medications.					
		cations were observed					
	1 "	7 to Resident #37. Next,					
	1	ed Resident #37's					
	nebulizer treatm	ent. She was observed to					
	handwash, turn t	the water off with her wet					
	hand, and then, o	dried her hands.					
	A. 10. On 6/22/	11 from 8:05 a.m. to 8:35					
	a.m., medication	pass was observed. As					
	LPN #9 was obs	erved preparing the					
	1	edications, she was					
		the Omeprazole					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155258		A. BUILDIN		00	(X3) DATE S COMPLI 06/23/2 (ETED	
	PROVIDER OR SUPPLIER		20	05 MAF	DDRESS, CITY, STATE, ZIP CODE RINE DRIVE SON, IN46016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	on top of her reporthe medication cathen picked up we cover and put it is with the rest of the Upon entering Romesident's admini (mouthpiece and were observed on beside table unconduring an intervior resident will set it was done with her Also, an orange of the medication of the floor, obtained pill from the medication the same medication than the same medications, then handwashed After the resident inhalers, LPN #9 oral medications, than 10 seconds, accucheck, and a less than 10 second during an intervione should handwashed and the dropped medications and the dropped medication an	al reflux disease) capsule out paper laying on top of fart. This same pill was with the same pill's paper in the medication cup ne oral medications. The esident #32's room, the stration nebulizer unit medication container) in top of the resident's overed. At this same time ew, LPN #9 indicated the et on the table after she er nebulizer treatment. Colored pill dropped from ap onto the floor. LPN pick this same pill off of ed another orange colored dication cart, placed it dication cart, placed it dication cup. After lent her inhalers, LPN #9 If for less than 10 seconds. It had administered her gave the resident her handwashed for less completed the resident's gain, handwashed for nds. At this same time ew, LPN #9 indicated wash for 15 seconds, and ications on the top of the hould had been thrown ed.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		INSTRUCTION 00	(X3) DATE COMPL	ETED	
		155258	B. WIN			06/23/2	011
NAME OF I	PROVIDER OR SUPPLIER		·	205 MA	ADDRESS, CITY, STATE, ZIP CODE RINE DRIVE		
COUNTF	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY		ANDER	SON, IN46016		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE
		wing current policies y the Director of Nursing 5 p.m.					
	The "Handwashi indicated the foll	ng/Hand Hygiene" policy owing:					
	1 * *	nust wash their hands for					
	at least fifteen (1	,					
		non-antimicrobial soap the following conditions:					
	and water under	the following conditions.					
	c. Before and a	after direct resident					
	contact (for whic	th hand hygiene is					
	1	eptable professional					
	practice);						
		ter performing any					
	blood sampling);	re (e. g., fingerstick					
		ving gloves or aprons; and					
	v. After complet						
	Procedure						
	Washing Hands						
	2. Vigorously	lather hands with soap					
	1 -	gether, creating friction to					
	all surfaces, for a	at least fifteen (15)					
	seconds						
	3. Rinse hands the	horoughly under running					
	water	11 24					
	1 -	oroughly with paper turn off faucets with a					
	towers and then t	turn on raucets with a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	ì '	TE SURVEY MPLETED	
		155258	B. WING		06/23	3/2011
	PROVIDER OR SUPPLIER	EALTH & LIVING COMMUNITY	205 M	ADDRESS, CITY, STATE, ZIP ARINE DRIVE RSON, IN46016	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	clean, dry paper	towel"				
	The "Personal Pr Using Gloves	otective Equipment -				
	5. Wash hands (Note: Gloves do handwashing.)	•				
		ION: GENERAL OCEDURES" policy				
	"Administratio	n				
	pass is completed before commence next resident. a) Hands may be alcohol-based ge between resident manufacturer's general manufacturer's	l or foam cleanser in s during med pass per uidelines. when gloves are used in ministering medications, washed with soap and d after the gloving"				
	•	y indicated the following:				
		npletion of the treatment t with mouth care and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155258		(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	TE SURVEY IPLETED 1/2011	
	PROVIDER OR SUPPLIER	EALTH & LIVING COMMUNITY	STREET 205 M	ADDRESS, CITY, STATE, ZIP C ARINE DRIVE RSON, IN46016	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	12. Disassemble mouthpiece, mas with warm water air dry completel bag for storage for the storage for	the nebulizer, k, and T-piece and rinse Allow the equipment to y, than place in a zip lock or future use.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155258		(X2) MUL: A. BUILDI B. WING		nstruction 00	(X3) DATE S COMPL 06/23/2	ETED	
NAME OF I	PROVIDER OR SUPPLIE			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					RINE DRIVE		
		EALTH & LIVING COMMUNITY			SON, IN46016		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	May 2011:						
	18 of 37 of the r	esident infection listing					
		umber for the resident.					
		sident infection listing					
		or evidence of the					
	infection.						
		esident infection listing					
	lacked the resolu	ution of the infection.					
	June 2011:						
		esident infection listing					
		umber for the resident.					
	4 of 24 of the real	sident infection listing					
	lacked the type of	or evidence of the					
	infection.						
	24 of 24 of the r	esident infection listing					
	lacked the resolu	ution of the infection.					
		ng of Infection" log lacked					
	1 -	or community acquired					
	· ·	ture or lab results or					
	1	or area in the building to					
	utilize for tracki	ng and trending purposes.					
	At this time duri	ng interview, the Director					
		ated the nurse who in					
		ogram was on vacation.					
	She indicated R	N # 13 did not formally					
		e infections. She					
		13 knows the residents					
	and if there are p	oatterns.					
	2.1.10(b)(1)(A)						
	3.1-18(b)(1)(A) 3.1-18(b)(1)(B)						
	[2.1-10(0)(1)(D)						

I '			(X2) MULTIPLE CO	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		155258	B. WING		06/23/2011
	RYSIDE MANOR HE	EALTH & LIVING COMMUNITY	205 MA	ADDRESS, CITY, STATE, ZIP CODE RINE DRIVE SON, IN46016	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0502 SS=D	services to meet the The facility is responding timeliness of the services of	review and interview, the ensure laboratory tests the lab as ordered by the fl 16 residents reviewed st in a sample of 19.	F0502	F502 I. Physician order was clarified lab test for patient #24 and the last was obtained per current or and plan of care. II. All patients with current lab orders were identified. These patients had current lab orders verified as needed and all lab te provided as ordered. III. The systemic change include that the clinical team will track lab orders and results received in morning clinical meeting Mond through Friday. The clinical team charge nurses have been educated regarding the new system for tracking, requesting lab test receiving results and determining that all lab tests are completed a ordered.	ders ders des all in the day am tem ss, ng
				IV. Director of Nursing/design	ee

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155258		A. BUILDING B. WING	00	COMPLETED 06/23/2011		
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DRIVE ANDERSON, IN46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	laboratory tests. On 6/21/11 at 4:4 information was Director of Nursof the above tests. On 6/22/11 at 8:3 the Director of Nursof the Director of Nursof the Director of Nursof	50 a.m., during interview, Jursing provided dated		will complete a review of lab daily (Monday through Frida per week for the next month, monthly for the next ten mon total twelve months of monit These reviews will include the tests are completed timely as and that results are obtained any identified concerns from will be addressed immediated. The results of these reviews are reported to the Quality Assur Committee. V. Completion date: 7/23/20	y), once then ths to oring. nat lab ordered timely. n audits y. will be ance	